1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07463

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07439

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
c. LENGTH OF STAY IN 1b: 20 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 1

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Addie — Middle: Mildred — Last: Andersen

4. DATE OF DEATH: Month: May — Day: 12 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 23 1887

9. AGE (In years last birthday): 79 yrs.

If UNDER 1 YEAR: Months / Days — If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salisbury, Md

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: R. Lee Waller

14. MOTHER'S MAIDEN NAME: Edith Rosa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: No 214-12-3780

17. INFORMANT: Mrs Rosa M. Taylor — Address: Ocean City Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion, Acute — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO (b): Arteriosclerotic & Cerebral
DUE TO (c): Insufficiency — 15 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: F. Townsend M.D.

EXAMINER'S NAME (Type): F. T. Townsend, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: May 15, 67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/15/67

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial

23d. LOCATION (City or Town) (County) (State): Berlin Wor Md

24. FUNERAL DIRECTOR: Anna A. Burbage — ADDRESS: Berlin, Md

25a. REC'D BY REGISTRAR DATE: MAY 19 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/66

1 4

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07464

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07440

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M 60 I 2 2

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill 23-1
d. STREET ADDRESS: 303 Willow St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Prince — Middle: Albert — Last: Ashby

4. DATE OF DEATH: Month: May — Day: 28 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 31, 1912

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Mill Work

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest Ashby

14. MOTHER'S MAIDEN NAME: Odella Hardy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-14-8799

17. INFORMANT: Odella L. Ashby — Address: 303 Willow St. Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Heart
DUE TO
(c): Disease — 10 yrs.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: David Rifat M.D.

EXAMINER'S NAME (Type): DAVID RIFAT

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-3-67

23c. NAME OF CEMETERY OR CREMATORY: Cool Spring Cem.

23d. LOCATION (City or Town) (County) (State): Girdletree Wor. Md.

24. FUNERAL DIRECTOR: Samuel Lauzé — ADDRESS: New Church, Va.

25a. RECD BY REGISTRAR DATE: JUN 2 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07465 07441

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural-Stockton
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Holland Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Pocomoke City 23-1
d. STREET ADDRESS: R.F.D. 3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First LINCIE Middle ELLA Last BARNES
4. DATE OF DEATH: Month May Day 20 Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 8, 1877
9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (County & State, or foreign country): Accomack County, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Hinman
14. MOTHER'S MAIDEN NAME: Mary Wessells
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): --
16. SOCIAL SECURITY NO.: 213-48-1281
17. INFORMANT Address: Mrs Robert Northam, Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS
331X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROSIS — 15 YRS
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): AMPU LOWER JOINTS - LOWER EXTREMITIES
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 14, 1967, to May 20, 1967, that (I) ~~(we)~~ last saw the deceased alive on May 17 1967, and that death occurred at 6A M, from the causes and on the date stated above.

22a. SIGNATURE: J. Edward Lamar — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 5/21/67
22c. PHYSICIAN'S NAME (Type): ROBERT C. LAMAR
22d. ADDRESS: SNOW HILL, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-22-1967
23c. NAME OF CEMETERY OR CREMATORY: Nelson Cemetery
23d. LOCATION (City, town or county) (State): Rural-Pocomoke, Maryland

24. FUNERAL DIRECTOR: Robert H. Watson
ADDRESS: Pocomoke City, Md.
25a. REC'D BY REGISTRAR DATE: MAY 26 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

Robert H. Watson

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07466 — 08872

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Worchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishopville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home Res.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishopville
d. STREET ADDRESS: Home Res.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elva — Middle Allen — Last Bunting
4. DATE OF DEATH: Month 5 — Day 23 — Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-1-1896
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Levi Bunting
14. MOTHER'S MAIDEN NAME: Anna Bunting
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 214-34-5351
17. INFORMANT — Address: Eva L. Bunting, Bishopville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hours.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Arteriosclerosis — 14 yrs.
DUE TO (c):
H201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/26, 19 67, to 5/15, 19 67, that (I) (we) last saw the deceased alive on 5/15, 19 67, and that death occurred at 4 A.M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-26-67
23c. NAME OF CEMETERY OR CREMATORY: Oddfellows Cemetery
23d. LOCATION (City, town or county) (State): Bishopville Md.

24. FUNERAL DIRECTOR — ADDRESS: C. Douglas Wilson, Frankford, Del.
25a. REC'D BY REGISTRAR — DATE: JUN 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

14

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07467

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07442

1. PLACE OF DEATH
a. COUNTY Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City
c. LENGTH OF STAY in 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1105 N. Baltimore Ave

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Virginia — b. COUNTY Northhampton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cape Charles 83-3
d. STREET ADDRESS RFD 1
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First Mary — Middle Edna — Last Chapman
4. DATE OF DEATH: Month May — Day 27 — Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 9, 1899
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Book Keeper
10b. KIND OF BUSINESS OR INDUSTRY: State Roads
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Coard S. Chapman
14. MOTHER'S MAIDEN NAME: Addie Mears
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) —
16. SOCIAL SECURITY NO. 225-32-9933
17. INFORMANT: Miss Hilda Harrison — Address: R1 Cape Charles, VA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO (b): ASCVD — 2 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE F J Townsend M.D.
EXAMINER'S NAME (Type) F J Townsend Jr
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county) Ocean City Md – Worcester Co.

22. DATE SIGNED: May 27 67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/29/67
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Capeville Methodist
23d. LOCATION (City or Town) (County) (State): Capeville Va.

24. FUNERAL DIRECTOR: Emma A. Bunting — ADDRESS: Berlin Md

25a. REC'D BY REGISTRAR DATE: MAY 31 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07468 — **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** — 07443

1 PLACE OF DEATH
a COUNTY: Worcester — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Stockton
c LENGTH OF STAY in b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland — b COUNTY: Worcester
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Stockton
d STREET ADDRESS: P.O. Box 153
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Arthur — Middle: — Last: Douglas
4 DATE OF DEATH: Month: May — Day: 15 — Year: 1967

5 SEX: Male
6 COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8 DATE OF BIRTH: Sept. 3, 1883
9 AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b KIND OF BUSINESS OR INDUSTRY: Farm
11 BIRTHPLACE (State or foreign country): Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: James Douglas
14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): —
16 SOCIAL SECURITY NO: 220-52-7964
17. INFORMANT: Elsie Douglas — Address: Stockton, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Heart Disease — Years.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitis - Poorly Controlled
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: David Rafat M.D.
EXAMINER'S NAME (Type): DAVID RAFAT
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 5/17/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 5-20-67
23c NAME OF CEMETERY OR CREMATORY: Home Beneficial Cem.
23d LOCATION (City or Town): Stockton (County): Wor. (State): Md.

24 FUNERAL DIRECTOR: Samuel Lough — ADDRESS: New Church, Va.
25a RECD BY REGISTRAR DATE: MAY 18 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (3) 6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

97469

CERTIFICATE OF DEATH

07443

1. PLACE OF DEATH
a. COUNTY: Worcester — Stockton MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Stockton Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holland Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Virginia — b. COUNTY: Accomack
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bloxom
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mamie — Middle: Pew — Last: Gladding
4. DATE OF DEATH: Month: 5 — Day: 21 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 4, 1889
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: — Days: 21 — IF UNDER 24 HRS: Hours: — Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Bloxom
12. CITIZEN OF WHAT COUNTRY: U S A.
13. FATHER'S NAME: Thomas Pew
14. MOTHER'S MAIDEN NAME: Priscilla Somers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 230-01-3203
17. INFORMANT: Adrian Gladding — Address: Hpeton Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept, 19 66 to May, 19 67 that (I) (we) last saw the deceased alive on 5-20 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 5/23/67
22c. PHYSICIAN'S NAME (Type): DAVID RAFAT
22d. ADDRESS: Snow Hill Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-23-67
23c. NAME OF CEMETERY OR CREMATORY: Parksley
23d. LOCATION (City or Town) (County) (State): Parksley Va

24. FUNERAL DIRECTOR: J Richard Johnson — ADDRESS: Parksley, Va.
25a. REC'D BY REGISTRAR — DATE: MAY 29 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

Items 18&20 Film 389 6-15

Item #7 Film #3 9 6/5/67 pc

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07470

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07445

1 PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sunset View Motel 48th St

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): District Heights
d. STREET ADDRESS: 7703 Alanie St. District Heights Apts
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Timothy — Middle: — Last: Holden
4. DATE OF DEATH: Month: May — Day: 27 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 28 1948
9. AGE (In years last birthday): 19 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Burris Holden
14. MOTHER'S MAIDEN NAME: Florence Crawford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 578-64-7112
17. INFORMANT: Address: Ocean City, Md Police Dept.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Aspiration of Vomitus — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Ethylism, acute

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18): Ethylism, Acute. Blood alcohol 0.42 percent vomited while asleep or unconscious and choked
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): Motel
20f. (City or town) (County) (State): Worc

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒ Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: F J Townsend Jr M.D
EXAMINER'S NAME (Type): F.J. Townsend Jr
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Ocean City Md

22. DATE SIGNED: May 27, 67 Worcester Co.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-31-1967
23c. NAME OF CEMETERY OR CREMATORY: Washington National
23d. LOCATION (City or Town) (County) (State): Suitland Maryland

24. FUNERAL DIRECTOR (Name and ADDRESS): Robert E. Wilhelm Funeral Home 4308 Suitland Rd Suitland Maryland

25a. RECD BY REGISTRAR DATE: MAY 31 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

37471

CERTIFICATE OF DEATH

07446

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b: 75 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: JEFFERSON ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SEVERN Middle J. Last HUDSON

4. DATE OF DEATH: Month MAY Day 11 Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: OCT. 10, 1880

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): DELAWARE

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM A. HUDSON

14. MOTHER'S MAIDEN NAME: ROSINA McCABE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MR. WILLIAM S HUDSON, BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c): Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Sept, 1966 to May 11, 1967 that (I) (~~we~~) last saw the deceased alive on May 11 1967, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Frank E. Gantz Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/13/67

22c. PHYSICIAN'S NAME (Type): Frank E. Gantz, Jr. M. D.
22d. ADDRESS: 5 Bay St. Berlin, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 5/15/67
23c. NAME OF CEMETERY ~~OR CREMATORY~~: BUCKINGHAM
23d. LOCATION (City, town or county) (State): BERLIN WOR MD

24. FUNERAL DIRECTOR ADDRESS: Irma A. Burbage Berlin Md
25a. REC'D BY REGISTRAR DATE: MAY 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07672 07447

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Worcester — MARYLAND; b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Berlin; c. LENGTH OF STAY IN 1b: 10 months; d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Berlin Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland; b. COUNTY: Worcester; c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Pocomoke City; d. STREET ADDRESS: 405 Laurel Street; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First REBECCA Middle LEE Last JOYNES

4. DATE OF DEATH: Month May Day 13 Year 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 28, 1881

9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Northampton County, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. West

14. MOTHER'S MAIDEN NAME: Virginia Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs Willis E. Boole, Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chr Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 Mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Neurocirculatory Hypertension

DUE TO (c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 2 -, 1967, to May 13 -, 1967, that (I) (we) last saw the deceased alive on May 2 - 1967, and that death occurred at 5P M, from the causes and on the date stated above.

22a. SIGNATURE: Chas R Law M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-13-67

22c. PHYSICIAN'S NAME (Type): Charles R. Law

22d. ADDRESS: Berlin Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-16-1967

23c. NAME OF CEMETERY OR CREMATORY: Redbank Cemetery

23d. LOCATION (City, town or county) (State): Marionville, Virginia

24. FUNERAL DIRECTOR: Robert H. Watson ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR DATE: MAY 17 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

Robert H. Watson

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only de ay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07473

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07448

1 PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Girdletree
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b COUNTY: Worcester
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Girdletree
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: Helen — Middle: E. — Last: NiblETT

4 DATE OF DEATH: Month: May — Day: 3 — Year: 1967

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: May 21, 1895

9 AGE (In years last birthday): 71 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: Own Home

11 BIRTHPLACE (State or foreign country): Baltimore, Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Thomas McCord

14 MOTHER'S MAIDEN NAME: Ida Funk

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16 SOCIAL SECURITY NO:

17 INFORMANT: Ernest C. Niblett — Address: Girdletree, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 6 Hrs
DUE TO (b): Thrombophlebitis — 1 wk.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Asteriosclerotic Heart Disease

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: David Rafat M.D.

EXAMINER'S NAME (Type): DAVID RAFAT

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED. CAL. EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 5-3-67

23a BURIAL, CREMATION REMOVAL (Specify): Burial

23b DATE THEREOF: 5-6-1967

23c NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial Park

23d LOCATION (City or Town) (County) (State): Howard County, Maryland

24. FUNERAL DIRECTOR: Lilly & Zeiler Inc. — ADDRESS: 1901-07 Eastern Ave.

25a RECD BY REGISTRAR DATE: MAY 4 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07475 07450

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POCOMOKE CITY,
c. LENGTH OF STAY IN 1b: 8 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POCOMOKE CITY
d. STREET ADDRESS: 212 MARKET ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ORVILLE Middle EDWARD Last PACE

4. DATE OF DEATH: Month MAY Day 21 Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV. 1, 1931

9. AGE (In years last birthday): 35 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TECHNICIAN

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CRAWFORD, NEBRASKA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DAMES O. PACE

14. MOTHER'S MAIDEN NAME: ROSELLE GALLIGAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: MRS. ORVILLE PACE PRINCESS ANNE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carbon Monoxide Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

733

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Reactive Depression

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: David Rafat M.D.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): DAVID RAFAT

Address (Street, city, town, or county):

DATE SIGNED: 5/21/67

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5/25/1967

22c. NAME OF CEMETERY OR CREMATORY: MOUNTVIEW CEMETERY

22d. LOCATION (City, town, or county) (State): BILLINGS, MONTANA

23. FUNERAL DIRECTOR: LEVIN R. WILSON PRINCESS ANNE, MD.

ADDRESS

24a. REC'D BY REGISTRAR DATE: MAY 31 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1SME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07474 07449

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Stockton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bay Road

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Stockton
d. STREET ADDRESS: Bay Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle OSCAR Last PARSONS
4. DATE OF DEATH: Month May Day 22 Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 13, 1882
9. AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY: Seafood
11. BIRTHPLACE (County & State, or foreign country): Worcester County, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Theodore Henry Parsons
14. MOTHER'S MAIDEN NAME: Henrietta Tarr
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): --
16. SOCIAL SECURITY NO: 220-32-1176
17. INFORMANT Address: Mrs Mary A. Parsons, Stockton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Cerebral Arteriosclerosis. — 4 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332K

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 19 64 to May, 19 67, that (I) (we) last saw the deceased alive on 5-2 19 67, and that death occurred at ____ M, from causes and on the date stated above

22a. SIGNATURE: David Rafat W. M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): DAVID RAFAT
22d. ADDRESS: Snow Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-25-1967
23c. NAME OF CEMETERY OR CREMATORY: Porterville Methodist
23d. LOCATION (City or Town) (County) (State): Stockton, Wor., Md.

24. FUNERAL DIRECTOR: Robert H. Watson — ADDRESS: Pocomoke City, Md.
Robert H. Watson
25a. REC'D BY REGISTRAR DATE MAY 29 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers — pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07476

CERTIFICATE OF DEATH

07451

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 207 S. Washington St.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 207 S. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle E. — Last SHOCKLEY

4. DATE OF DEATH: Month May — Day 1, — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 6, 1902

9. AGE (In years last birthday): 64 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10b. KIND OF BUSINESS OR INDUSTRY: State Roads Comm.

11. BIRTHPLACE (County & State, or foreign country): Worcester, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Shockley

14. MOTHER'S MAIDEN NAME: Dollie Hancock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): -

16. SOCIAL SECURITY NO: 213-42-2443

17. INFORMANT: Mrs. Myrtle D. Shockley, Address: Snow Hill Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO
(b): generalized arteriosclerosis — 4 yrs
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Long, 1963, to May, 1967 that (I) (we) last saw the deceased alive on 1967, and that death occurred at 12:15 A.M. from causes and on the date stated above

22a. SIGNATURE: John T. Bulkeley — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-5-67

22c. PHYSICIAN'S NAME (Type): John T. Bulkeley MD

22d. ADDRESS: Pine Bluff Rd. Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/3/1967

23c. NAME OF CEMETERY OR CREMATORY: Whatcoat Methodist

23d. LOCATION (City or Town) (County) (State): Snow Hill, Maryland

24. FUNERAL DIRECTOR: Gerald C. Townsend — ADDRESS: Snow Hill, Maryland

25a. REC'D BY REGISTRAR: DATE MAY 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07477

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07452

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Pocomoke
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Pocomoke
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Carbie — Middle: E. — Last: Smack

4. DATE OF DEATH: Month: May — Day: 15, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]

8. DATE OF BIRTH: 9/4/93

9. AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Truck

11. BIRTHPLACE (State or foreign country): Worcester Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Smack

14. MOTHER'S MAIDEN NAME: Mary Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): --------

16. SOCIAL SECURITY NO.: 216561276

17. INFORMANT: Dorothy Bennett, Address: 520 E. Isabella St. Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b): Arteriosclerotic Heart — years
DUE TO
(c): Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Alcoholism

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X] Inquiry [X] and in my opinion death resulted from Natural causes [X] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: David Lapp M.D.

EXAMINER'S NAME (Type): DAVID RAFAT

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)

22. DATE SIGNED: 5-16-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 18/67

23c. NAME OF CEMETERY OR CREMATORY: Salem Meth.

23d. LOCATION (City or Town) (County) (State): Pocomoke, Maryland

24. FUNERAL DIRECTOR: Herman G. Lyons — ADDRESS: Snow Hill, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 18 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07478

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Stockton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) 07653
a. STATE: Md. — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Stockton
d. STREET ADDRESS: Route 2, Box 109
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: David — Last: Taylor
4. DATE OF DEATH: Month: May — Day: 9 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 18, 1891
9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Dallas Taylor
14. MOTHER'S MAIDEN NAME: Hester ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 218-20-5552A
17. INFORMANT: Gladys Taylor — Address: Route 2 Stockton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Vascular Accident. — 6 wks
DUE TO (c): Generalized Arteriosclerosis
331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/65, 19__, to 5/9, 1967, that (I) (~~was~~) last saw the deceased alive on 5/9/67 19__, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W. J. Fletcher M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 5/10/67
22c. PHYSICIAN'S NAME (Type): Dr. F. Fletcher, Jr. — 22d. ADDRESS: Hasey, Va., Accomack Co.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 5-13-67 — 23c. NAME OF CEMETERY OR CREMATORY: Coolspring Cem. — 23d. LOCATION (City, town or county) (State): Girdletree, Md.

24. FUNERAL DIRECTOR: Samuel Savage — ADDRESS: New Church, Va. — 25a. REC'D BY REGISTRAR OF DATE: MAY 15 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07473 Item 2 Film 0390 5/11/67 kk 07454

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WORCESTER
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): BERLIN NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BERLIN Snow Hill
d. STREET ADDRESS: [illegible] Bay St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HETTIE Middle A. Last WEST
4. DATE OF DEATH: Month MAY Day 2 Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 8, 1880
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: RETD.
11. BIRTHPLACE (County & State, or foreign country): COULBOURNE DIST. MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: BURTON WEST
14. MOTHER'S MAIDEN NAME: HETTIE A. RUARK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: MRS. MILDRED DAVIS BERLIN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocarditis — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic Myocarditis
DUE TO (c): Arthritis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-1-67 19 to 5-2-67 19, that (I) (we) last saw the deceased alive on 5-3-67 19 and that death occurred at 6:A M, from the causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schabb M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Clifford E. Schabb
22d. ADDRESS: Berlin Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 5 | 5 | 67
23c. NAME OF CEMETERY OR ~~CREMATORY~~: BAPTIST CHURCHYARD
23d. LOCATION (City, town or county) (State): SNOW HILL Worc. MD

24. FUNERAL DIRECTOR: Anna A. Burbage
ADDRESS: Berlin Md
25a. REC'D BY REGISTRAR DATE: MAY 8 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64